



Application for Transportation Services

(Veterans Services, Persons with Disabilities (PwD), ADA, Senior Shared Ride 65+, Public Full Fare)

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
 - You served in the armed services
 - You are currently on Medical Assistance through the Department of Human Services
 - You are a person with a disability between the ages of 18-64
 - You are a person who lives along a fixed route, but due to a disability cannot access it
 - You are aged 65+
2. If you would like to apply, please complete the application for transportation services and send it with any copies of qualifying documents to the address below.



901 N Cameron Street
Harrisburg, PA 17101

3. Applications are processed in the order in which they are received.
4. For ADA customers, if we have not processed your application within 21 days of receipt, you will be given presumptive eligibility until we are able to make an eligibility determination.
5. Incomplete or missing information or documents will delay processing.
6. Once processed, a Mobility Planner will contact you to notify you of your eligibility.

If you have any questions or need this application in an alternate format, please call **Mobility Planning at 1-800-632-9063**.

NOTE: The information provided in this application regarding your veteran status, age, disability, and county of residence will be used to determine your eligibility for shared ride transportation services under various programs including the Rural Transportation for Persons with Disabilities and Senior Shared Ride programs.

Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and provide you with the appropriate referral service (MATP, ADA, MD/IDD). This information is kept confidential and is used only by the professionals involved in evaluating your eligibility.

Please Print

Ecolane ID: _____

How did you first learn about CAT's paratransit system?

Hospital/Clinic Flyer

Saw a Bus

Friend/Family Member

Senior Center

Case Worker

Advertisement: (Publication)

CAT's Information Booth (Prime of Life, Expos, Mall)

Other: (Specify)

GENERAL / QUALIFYING QUESTIONS

First Name:

Middle Name:

Last Name:

Date of birth:

SSN:

Age:

Current address:

City:

State:

Zip code:

Email:

Home Phone:

Cell Phone:

County:

Emergency Contact:

Relationship:

Phone #:

AGE VERIFICATION: Please send a legible photo copy of one of the listed forms of proof of age along with this application
A Medicare card is not an acceptable proof of age. Please check which verification you are enclosing.

<input type="checkbox"/> Armed forces discharge/separation papers	<input type="checkbox"/> Pennsylvania ID card
<input type="checkbox"/> Passport/naturalization papers	<input type="checkbox"/> Photo motor vehicle driver's license
<input type="checkbox"/> Baptismal certificate	<input type="checkbox"/> Birth certificate (Maiden Name) _____
<input type="checkbox"/> PACE ID Card	<input type="checkbox"/> Veteran's Universal Access ID Card
<input type="checkbox"/> Statement of age from U.S. Social Security Office	<input type="checkbox"/> Resident Alien Card

VETERAN SERVICE VERIFICATION: Please send a legible photo copy of proof of veteran service with this application
Please check which verification you are enclosing.

<input type="checkbox"/> Armed forces discharge/separation papers	<input type="checkbox"/> Veteran's Universal Access ID Card
<input type="checkbox"/> DD-214	<input type="checkbox"/> Driver's License with Veteran's Designation

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY- ONLY IF YOU ARE UNDER 65 YEARS OF AGE

In order to be eligible based on a disability, the Certification of Disability must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability and are **required** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.

<i>Office of Vocational Rehabilitation (OVR)</i>	<i>Bureau of Blindness and Visual Services</i>	<i>Registered Nurse</i>
<i>Disability Insurance (SSDI)</i>	<i>United Cerebral Palsy</i>	<i>PA Attendant Care Program</i>
<i>Community Services Program for Persons with Physical Disabilities</i>	<i>Registered Physical/Occupational Therapist</i>	
<i>Mental Health/Intellectual & Developmental Disability(MH-IDD)</i>	<i>Center for Independent Living (CIL)</i>	<i>Other</i> _____

NEEDS ASSESSMENT

What is your primary language?

Do you have a medical assistance card? Yes No

Do you have a disability according to the Americans w/ Disabilities Act (ADA)? If yes, attach the *Certification of Disability Form*

Do you have any mobility devices such as...

<input type="checkbox"/> Manual Wheel Chair	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Cane
<input type="checkbox"/> Motorized Scooter	<input type="checkbox"/> Power Wheel Chair	<input type="checkbox"/> Walker
<input type="checkbox"/> Crutches	<input type="checkbox"/> Guide Dog	Other _____

Do you require the services of a personal care assistant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination) Yes No Sometimes

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

By signing below I hereby agree to report any changes to this Service Provider regarding my eligibility for funding assistance. I understand that giving knowingly false statements is a criminal offense The information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

Signature of person completing this form _____ Date: _____

Please be sure to include the following with your application

- Proof of Age
- Proof of Veteran Status
- Certificate of Disability (Page 6)
- Ensure your application is signed

**Veteran Applicants: If you are Applying for Only Veterans Services, the Application Ends HERE!
All Other Applicants: Please Continue with this Application!**

CURRENT TRAVELDo you currently use CAT's **fixed route** bus services? Yes No SometimesDoes the weather affect your ability to use CAT's fixed route bus service? Yes No

If yes, please explain:

List your most frequent destinations and how you get there now

Destination address where you go	How often do you go there?	How do you get there?
1.		
2.		

ENVIRONMENT AROUND YOUR RESIDENCE

How many steps are there at the entrance you use at your residence?

Can you get to a vehicle without the help of another person? Yes NoHow would you describe the terrain where you live? Steep Hill Paved Lane Unpaved laneAre there sidewalks in your neighborhood? Yes No**MOBILITY FUNCTIONAL ASSESSMENT**For each below question, check **one** answer. Your answers should be based on: how you feel most of the time; under normal circumstances; using your mobility equipment; and whether you can perform this activity independently.**Without the help of someone else, can you:**

Walk up and down three steps if there are handrails on both sides?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Use the telephone to get information?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Cross the street, if there are curb cuts?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Ride up and down a wheelchair lift with handrails on both sides?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Find your way to the bus stop, if someone shows you the way?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Currently travel by yourself?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Wait 10 minutes in good weather outdoors without a place to sit?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Step on and off the curb from a sidewalk?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Travel up or down a gradual hill on the sidewalk, in good weather?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
Travel 3 level blocks, on the sidewalk, when the weather is good?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	<input type="checkbox"/> Unsure
If you are able to do this, how long does it take you?	<input type="checkbox"/> < 5 min	<input type="checkbox"/> 5 – 10 min	<input type="checkbox"/> > 10	<input type="checkbox"/> Unsure
Have you ever gotten lost when traveling alone?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

If the weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk, using your mobility aid? (Please select the box which most closely your answer)

<input type="checkbox"/> I cannot travel alone	<input type="checkbox"/> Less than 1 block	<input type="checkbox"/> 3 blocks	<input type="checkbox"/> 6 blocks
<input type="checkbox"/> Curb in front of house	<input type="checkbox"/> 9 blocks	<input type="checkbox"/> More than 9 blocks	Other _____

Have you ever received training to learn how to use the bus or travel around the community? Yes No

If yes, which agency or person provided the training? _____ When were you trained? _____

Did you successfully complete the training? Yes No If no, why not? _____Was your training route specific? Yes No Which routes did you learn? _____Would you like to participate in training to learn to ride the bus? Yes No

DUPLICATION OF TRANSPORTATION SERVICESDo you currently receive any transportation services? Yes No

Are any of your transportation costs paid for by another program or organization? (Select from below all that apply)

<input type="checkbox"/> Senior Citizens Shared Ride Transportation Program	<input type="checkbox"/> Office of Vocational Rehabilitation (OVR)
<input type="checkbox"/> Medical Assistance Transportation Program	<input type="checkbox"/> Mental Health/Mental Rehabilitation (MH/IDD)
<input type="checkbox"/> Americans w/Disabilities Act Complementary Paratransit	<input type="checkbox"/> Area Agency on Aging
<input type="checkbox"/> Group Home (Where you live)	<input type="checkbox"/> Other _____

ADA Applicants: If you are Applying Specifically for ADA Services, the Application Ends HERE!
All Other Applicants: Please Complete the Remainder of this Application!

DEMOGRAPHIC INFORMATION The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Offices for Aging, Inc. for reporting purposes.

Ethnic Information:

White African American Am Indian/Alaskan Native Asian American/Pacific Islander Hispanic Origin Do you live alone? Yes NoDo you have adequate housing? Yes No**INCOME AND HOUSEHOLD RELATED DATA**

If you are NOT registered for the Medical Assistance Transportation Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments

After reviewing the chart below I think that...

 I'm already registered with MATP I may qualify for MATP I do not think I qualify for MATP

**UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
2021 POVERTY GUIDELINES**

Household Size (select one)	Annual Income (select one)		
<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> less than \$14,820	<input type="checkbox"/> \$14,821 - \$20,040	<input type="checkbox"/> \$20,041 - \$25,260
<input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> \$25,261 - \$30,480	<input type="checkbox"/> \$30,481 - \$35,700	<input type="checkbox"/> \$35,701 - \$40,920
<input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> \$40,921 - \$46,140		<input type="checkbox"/> \$46,141-\$51,360
<input type="checkbox"/> 7 <input type="checkbox"/> 8	For families/households with more than 8 persons, add \$5,220 for each additional person.		

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by CAT.

I give my permission to CAT to contact a healthcare or other professionals that I designate for additional information to verify that I am a person with a disability. Yes No

By signing below, I hereby agree to report any changes in circumstances immediately to this Service Provider regarding my eligibility for funding assistance. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services hearing. This affirmation statement covers this application and all attachments required for the determination of eligibility. I am authorizing that, in the event that the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the PA Department of Human Services regulations, you have my permission to do so. The information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

Your signature (or name person who completed this form) _____

Date: _____ Relationship: _____ Contact Number: _____

MAILING INSTRUCTIONS: Please check the following before mailing your application

- Include a copy of ONE form of proof of age
- Include a copy of any other important documents such as the Certification of Disability Form on Page 6
- Sign the Release of information and Certification of Application section

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY

In order to be eligible based on a disability, the Certification of Disability (last page) must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability is **required** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.

<i>Office of Vocational Rehabilitation (OVR)</i>	<i>Bureau of Blindness and Visual Services</i>	<i>Registered Nurse</i>	
<i>Disability Insurance (SSDI)</i>	<i>United Cerebral Palsy</i>	<i>PA Attendant Care Program</i>	<i>Physician</i>
<i>Community Services Program for Persons with Physical Disabilities</i>		<i>Registered Physical/Occupational Therapist</i>	
<i>Mental Health/Mental Retardation Program (MH-MR)</i>	<i>Center for Independent Living (CIL)</i>	<i>Other _____</i>	

Information contained in this application will be kept confidential and shared only with professionals involved in evaluating your eligibility and appropriate CAT personnel. CAT staff may need to talk to the applicant later to get more information.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
 Yes No No, I am already registered to vote where I live now.

Certification of Disability Form

Reduced Fare Transportation Services

Transportation for Persons with Disabilities (PwD) and ADA Program

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. **This form is to be completed by a professional who is familiar with the applicant's disability. A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities.** The applicant has applied for transportation services under the Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Capital Area Transit. If you have any questions about the form, please call 717-846-RIDE (7433) or toll free at 1-800-632-9063.

Applicant Information to be completed by applicant (A completar por el solicitante):

Last Name: _____ First Name: _____ M.I.: _____

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ E-mail: _____

Applicant or Applicant Representative signature

Date

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disabilities Act (ADA). According to the ADA, "*Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". "...*major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Please answer the following questions to be completed by the agency or person providing verification of eligibility information (Hecho por profesional):

How many blocks can this person walked unassisted? (Circle One) <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks

Is the applicant's disability permanent? Yes No
 (A standard definition of a permanent disability is one that lasts for 12 months or longer.)

If not, how long is it expected to last? _____

What is the nature of the applicant's disability? Check those that apply.

Please check all mobility aids that apply.

Mobility disability (please see question to the right)

Manual wheelchair

Crutches

Vision disability

Power Wheelchair

Cane

Hearing disability

Motorized Scooter

Walker

Cognitive disability

Guide/Service Dog

White Cane

Mental disability

Requires Personal Assistant (nurse, health aide, etc.)

Other — Please specify: _____

Requires Escort

Signature of Professional

Date

Title

Name of Agency or Organization

Address

Telephone

Please send completed form to:

Capital Area Transit

901 N Cameron Street, Harrisburg, PA 17101